USAID | NIGERIA
FROM THE AMERICAN PEOPLE

HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population[1]	170 million (mid-2012)
Estimated Population Living with HIV/AIDS[2]	3.3 million [2,900,000–3,600,000] (2009)
Type of Epidemic[2]	Generalized
Percentage of HIV-Infected People Receiving Antiretroviral Therapy[3]	26% (2009)
Percentage of HIV-Infected Pregnant Women Receiving Antiretroviral Therapy for PMTCT[3]*	9% [7%–10%] (2010)

*No exact coverage can be presented, as the estimated number of pregnant women living with HIV in need of antiretroviral medicine is currently being reviewed and will be adjusted, as appropriate, based on ongoing data collection and analysis.

Overview

The most populous country in Africa, Nigeria accounts for more than half of West Africa's population. Nigeria's first case of AIDS was reported in 1986, and the national prevalence soon rose rapidly, from 1.8 percent in 1991 to a peak of 5.8 percent in 2001.[4] The national adult HIV prevalence rate was 3.6 percent in 2009, with an estimated 3.3 million people living with HIV/AIDS (PLWHA).[2] After South Africa, Nigeria has the largest number of PLWHA in the world.

Significant regional variation in the epidemic exists, with Ekiti State in the southwest zone of Nigeria having the lowest prevalence (1 percent) and Benue State in the north-central zone having the highest (10.6 percent).[4] Variation in prevalence is also seen in gender, where women are disproportionately affected by the epidemic. In 2009, prevalence among young women aged 15 to 24 was higher than the prevalence among young men of the same age (2.9 percent and 1.2 percent, respectively).

Most-at-Risk-Populations. Most-at-risk populations are also disproportionately affected by the epidemic, including female sex workers (FSWs), men who have sex with men (MSM), and, to a lesser extent, injecting drug users (IDUs). Of these groups FSWs are most affected by HIV/AIDS.[5] Brothel based FSWs have HIV prevalence rates of 27.4 percent, on average, and non-brothel-based FSWs have rates of 21.1 percent. Prevalence rates of 46.7 percent and 46.3 percent were found in the Benue and Nassarawa States, respectively. Lagos State had the lowest rate of HIV infection among brothel-based FSWs at 12.1 percent, while Cross River State recorded the lowest rate for non-brothel-based sex workers at 8.3 percent. Over 80 percent of FSWs in all six of the surveyed states reported using condoms consistently with clients. However, consistent condom use with boyfriends was substantially lower (21 percent among brothel-based workers and 26 percent among non-brothel-based workers)[5] – a situation that may spread HIV to the general population.[4] Prevalence among brothel-based FSWs was highest among those aged 25 to 49, but among young sex workers (15 to 19), prevalence was still as high as 24.3 percent, suggesting that sex workers are infected early in their careers.[5]

Among six states that were surveyed in 2010, the average overall prevalence rate among MSM was 17.2 percent. HIV prevalence was highest in the Federal Capital Territory, at 37.6 percent.[5] While MSM appeared to have high levels of HIV prevention knowledge, consistent condom use was lower among MSM than FSWs. Just 25 percent of MSM had been exposed to safe sex education from peer outreach workers. Sexual relationships with women, a potential means of spreading HIV to the general population, were common.[5]

IDUs are at high risk of HIV infection. In 2010, 4.2 percent of this population was HIV-positive. (Of the 6 states surveyed, the Federal Capital Territory had the highest prevalence rate, at 9.3 percent.[5]) IDUs in the Federal Capital Territory often injected drugs more than once a day and less than 40 percent consistently used sterilized needles. Female IDUs had about seven times higher HIV prevalence than their male counterparts. About 20 percent of IDUs reported sex with FSWs, and the IDUs surveyed had low condom use. About 73 percent of IDUs surveyed had received HIV education within the 12 months preceding the survey.[5]

Transport workers, armed forces, and police personnel are also at-risk populations, with HIV prevalence ranging from one percent to eight percent.[5] Over 20 percent of each of these predominantly male occupational groups reported multiple sexual partnerships within the past 12 months.[5]

Children and HIV/AIDS. Children are also affected by the epidemic. Some children contract HIV from their mothers during pregnancy, birth, or breastfeeding. In 2009, an estimated 360,000 children in Nigeria were living with HIV.[2] Most do not have access to antiretroviral therapy (ART). In 2010, only 7 percent of children living with HIV were benefiting from ART, leaving an unmet need of 262,000. Moreover, the percentage of pregnant HIV-positive women who receive the most effective drug regimen for the prevention of mother-to-child transmission of HIV (PMTCT) is similarly low, at nine percent.[3] Nigeria also has one of the largest orphans and vulnerable children (OVC) populations in the world – approximately 17 million. In 2009, 2.5 million children in Nigeria had been orphaned by AIDS.[2] Additionally, it is estimated that up to 10.7 percent of the 69 million children in Nigeria are vulnerable to AIDS.[6]

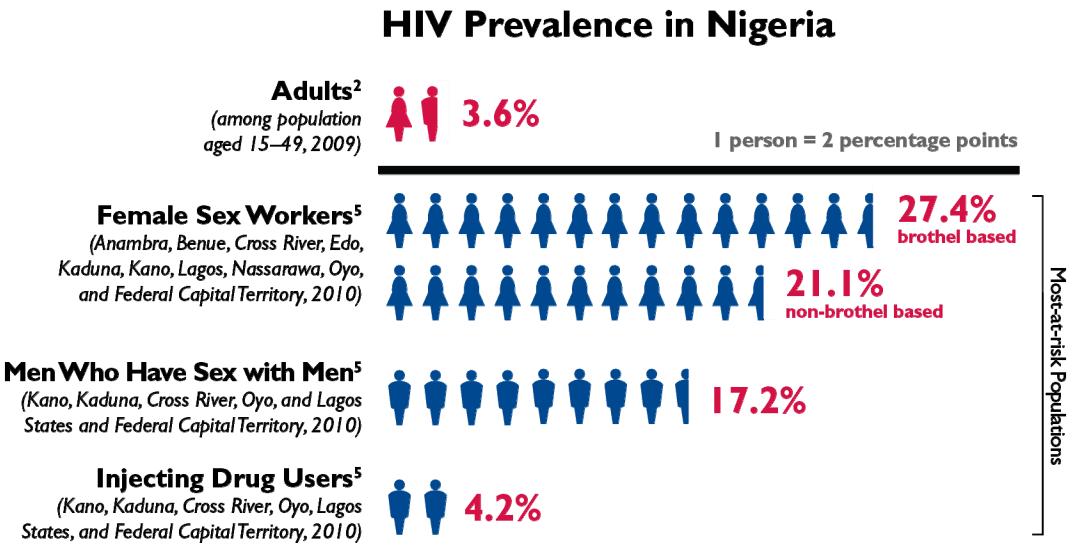
Tuberculosis and HIV Co-infection. PLWHA are particularly vulnerable to tuberculosis (TB). They have increased susceptibility to infection and progression to active TB; consequently, TB is one of the main causes of death for PLWHA. The World Health Organization ranks Nigeria as 10th among the 22 countries with the highest absolute number of TB cases. Collectively, these 22 countries represent 80 percent of the estimated new TB cases worldwide. PLWHA are more likely to become infected with TB, a leading killer of HIV-positive people. Without treatment, those with TB-HIV co-infection die in a few months. Nigeria had an incidence rate of 133 cases per 100,000 population in 2010.[7]

National Response

Nigeria's health sector response to the HIV/AIDS epidemic was launched in 1986, after the first case of AIDS was reported. With the start of democratic rule in 1999, the Government of Nigeria initiated the move from a health-centered response to a national multisectoral response. In 2001, the Presidential Council on AIDS and the National Action Committee on AIDS (NACA) were created to coordinate activities at the federal level. At the state and local levels, coordination was performed by the State Action Committee on AIDS and the Local Government Action Committee on AIDS, which continue to coordinate the state and local responses today. An HIV/AIDS action plan was developed. It addresses sociocultural, informational, and systematic barriers in order to advance prevention, care, support, and the creation of an enabling environment.[4]

Under NACA's leadership, a second National Strategic Framework was developed in 2009 for 2010–2015 and serves as a comprehensive strategic plan that covers areas such as prevention, care, and treatment. The framework prioritizes improving program uptake, behavioral change, gender-sensitive health services, and non-health responses. It also prioritizes monitoring and evaluation research and the creation of an enabling social, legal, and political environment. NACA was transformed in 2007 into the National Agency for the Control of AIDS to give it more authority and improve efficiency and accountability.[4]

Public Private Partnerships. The country's public sector response is multisectoral, and the health sector response is led by the Ministry of Health through the National AIDS and Sexually Transmitted Infection Control Program. Nigeria has also worked to develop its public-private partnerships as a means to create a sustainable national response. Through the Nigeria Business Coalition against HIV/AIDS and the U.S. Agency for International Development (USAID)-funded Smartwork project, more than 70 national and multinational companies, such as Coca-Cola, Cadbury, Guinness, and Chevron, have supported workplace programs and outreach programs to the public. For example, NACA partnered with ECOBANK to establish seven youth-friendly reproductive health service centers in seven universities. Airtel, a telecommunications provider, supports 20 toll-free telephone lines for HIV/AIDS information services provided by a local nongovernmental organization. In addition, a partnership comprising NACA, Nigeria Liquefied Natural Gas Limited, Shell, and Exxon-Mobil with the New Nigerian Development Company provides comprehensive prevention, treatment, and care to communities in the Niger Delta.[4]



Civil society organizations (CSOs) also play a key role in the HIV/AIDS response, particularly through involvement in community engagements to limit the impact of HIV/AIDS. The Civil Society Consultative Group on HIV/AIDS in Nigeria, established in 2002, provides an opportunity for local CSOs to provide input in policy formulation and development. This Group is also involved in the consultation process of the World Bank Multi-Country HIV/AIDS Program to ensure the World Bank HIV/AIDS Fund reflects the needs of CSOs.[4]

Monitoring and Evaluation. The Ministry of Health and the National Population Commission, with support from NACA and other stakeholders, have instituted regular surveillance using several facility- and population-based surveys to monitor trends in prevalence, inform intervention response priorities, and measure the effectiveness of various public health interventions to control the epidemic. Key surveys include the National HIV/AIDS and Reproductive Health Survey Plus, the Integrated Biological and Behavioral Surveillance Survey, a clinic-based antenatal care survey, and the Nigeria Demographic and Health Survey.[4]

In 2009, Nigeria invested in modes-of-transmission modeling with support from the Joint United Nations Programme on HIV/AIDS and the World Bank. The model estimates the distribution of new infections and identifies those populations at highest risk. The model further estimates that 23 percent of new infections will be among most-at-risk populations, who comprise about 1 percent of the population, and 40 percent will be among most-at-risk populations and their partners. Another 42 percent of infections will be among the general population; these infections will be due primarily to high sexual networking and low condom use.[4]

Antiretroviral Therapy. An estimated 26 percent of PLWHA in need of ART were receiving it in 2010. A free ART provision policy has led to increased access and uptake, with the annual number of ART clients increasing sevenfold, from 41,224 in 2005 to 302,973 in 2009.[3] Financial support has been provided by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Global Fund Investment in Nigeria's Epidemic. Since 2003, the Global Fund has approved $325.8 million in grants to support HIV/AIDS programs in Nigeria. As of March 2012, Nigeria had six Global Fund grants in process.[8] The largest of these grants ($50.9 million) was awarded to NACA to reduce HIV/AIDS morbidity and mortality. The grant supports activities in HIV/AIDS prevention, care, and treatment; TB-HIV; and health systems strengthening, as well as policy development, including workplace policy. The second largest grant ($14 million), which was awarded to the Society for Family Health, focuses on the delivery of behavior change communications through community outreach and mass media. The third largest grant ($12.8 million) was issued to the Civil Society for HIV/AIDS to scale up gender-sensitive HIV/AIDS prevention, treatment, and care, and to support interventions for adults and children in Nigeria. Grant activities will focus on community outreach for HIV prevention, support for OVC, and care and support for the chronically ill.[8] The U.S. Government provides nearly 30 percent of the Global Fund's total contributions worldwide.[9]

USAID Support

In fiscal year 2011, Nigeria received $471 million from PEPFAR through USAID for essential HIV/AIDS programs and services. Launched in 2003, PEPFAR supports nations around the world in their response to HIV/AIDS. PEPFAR, a cornerstone of President Obama's Global Health Initiative (GHI), improves and expands access to health services in partner countries. The U.S. Government through PEPFAR and USAID is committed to strengthening health systems, with a particular focus on improving the health of women, newborns, and children.

Partnership Framework. In 2010, the U.S. Government, through PEPFAR, and the Government of Nigeria established a Partnership Framework, which provides a 5-year joint strategic plan for cooperation among the Government of Nigeria, the U.S. Government, and other stakeholders to support a collaborative response to HIV. The Partnership Framework specifies the expected roles of the governments of Nigeria and the United States in this response over the 5-year period.

During 2011, the U.S. Government identified the following as priorities for its HIV/AIDS prevention, treatment, and care efforts in Nigeria: improved human resources for health; greater focus on women and children; delivery of highest-impact service interventions, particularly at the primary health care level; and strengthened leadership, management, governance, and accountability for program ownership and sustainability.

Capacity Building. U.S. Government technical assistance to the Government of Nigeria is shifting its focus to state and local levels of government to improve capacity in planning, management, and leadership of HIV/AIDS and TB programs. U.S. Government activities supported a nationwide decentralization effort to make services more accessible to beneficiaries. For example, a new focus on improving primary health care centers has made it possible for many of them to provide ART, thus increasing opportunities to start new patients on ART.

Following the introduction of a minimum prevention package intervention in Nigeria, the U.S. Government engaged in a concerted effort to build implementing partner capacity to use the intervention successfully. In its work to prevent mother-to-child-transmission of HIV, the U.S. Government realigned the service approach to more effectively provide pregnant women with integrated antenatal care and PMTCT services. Moreover, U.S. Government PMTCT efforts have increased engagement with state and local governments to build their technical capacity in planning, implementation, and coordination of HIV/AIDS programs. Other strategies used to improve PMTCT included integrating PMTCT services into maternal, newborn, and child health service outlets and increasing private sector engagement for PMTCT service expansion. Meanwhile, other prevention efforts were realigned to prioritize an approach that combines a set of biomedical, behavioral, and structural interventions that are in line with the minimum prevention package intervention. This realignment also prioritized behavioral interventions to minimize sexual risk and increase protection in focus populations, and partner mass media campaigns with community and social mobilization initiatives that either include or promote behavioral interventions.

Scaling Up Antiretroviral Therapy. In its treatment efforts, the U.S. Government continues to focus on identifying people eligible for HIV/AIDS treatment. Partners are encouraged to use a provider-initiated counseling and testing approach for all patients receiving care in health facilities. Plans continue for scaling up ART services to more than 500,000 Nigerians by focusing on high-burden states and states with high unmet need. In these states, planned strategies include early identification of HIV-infected persons, retention in care, and greater use of pooled procurement by single agencies. The U.S. Government also works to increase ART access and coverage among HIV-infected children and to reduce the number of deaths from pediatric HIV/AIDS.

TB-HIV Services. The U.S. Government supports collaborative TB-HIV activities in more than 844 facilities in 36 states, with 1,864 health community workers trained to provide TB-HIV services in 2011. As a result, 490,791 HIV-positive individuals received care and treatment for HIV and were tested for TB at TB service outlets, with 20,521 TB-HIV cases on treatment in PEPFAR-supported sites in 2011. Directly Observed Treatment, Short-course services were also expanded to 48 health facilities and 24 laboratories that serve HIV-positive patients. The proportion of TB patients tested for HIV in 2011 was 79 percent, with a 25 percent TB-HIV co-infection rate.

Orphans and Vulnerable Children. The USAID OVC program seeks to support a better functioning social service system to provide early childhood development opportunities, child protection, and a vital safety net for children and families under stress. The program provides life skills and HIV prevention activities to OVC, strengthens the economic capacities of households, empowers caregivers, and assists children and families through networking and referrals. The OVC program sustains and enhances existing community structures by involving communities in its planning, implementation, and evaluation. It also engages them in efforts to advocate

for access to and quality in essential services (health, education, nutrition, etc.). Moreover, the program supports communities in efforts to monitor service quality and access. The program also strengthens coordinating bodies at the state and the Local Government Area levels. More broadly, it improves the social welfare workforce. Furthermore, the OVC program is aimed at providing support that is need-based, age-appropriate, gender-sensitive, quality-focused, evidence-based, and cost-effective. In 2010, 255,100 were receiving support.

Important Links and Contacts

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USAID's HIV/AIDS website for Nigeria:
http://transition.usaid.gov/our_work/global_health/aids/Countries/africa/nigeria.html

West Africa Regional HIV/AIDS website:
http://transition.usaid.gov/our_work/global_health/aids/Countries/africa/waregional.html

For more information, see USAID's HIV/AIDS website: *http://transition.usaid.gov/our_work/global_health/aids/*

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References

1. United States Census Bureau. International Data Base. 12.0321:http://www.census.gov/population/international/data/idb/region.php. Accessed March 15, 2012.
2. Joint United Nations Programme on HIV/AIDS. *Global Report: UNAIDS Report on the Global AIDS Epidemic: 2010.* Geneva, Switzerland2010.
3. WHO, UNAIDS, UNICEF. *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access.* Geneva, Switzerland 2011.
4. National Agency for the Control of AIDS. *United Nations General Assembly Special Session (UNGASS) Country Progress Report: Nigeria*: UNAIDS; March 2010.
5. Federal Ministry of Health. *Nigeria HIV Integrated Biological and Behavioural Surveillance Survey*2010.
6. Nigerian Federal Ministry of Women Affairs and Social Development. *The 2008 Situation Assessment and Analysis on Orphans and Vulnerable Children (OVC) in Nigeria: Key Findings.* Abuja, Nigeria2008.
7. World Health Organization. *Global Tuberculosis Control 2011*. Geneva, Switzerland 2011.
8. Global Fund to Fight AIDS, Tuberculosis, and Malaria. Grant Portfolio: Nigeria. 2012; http://portfolio.theglobalfund.org/en/Country/Index/NGA. Accessed March 18, 2012.
9. Global Fund to Fight AIDS, Tuberculosis, and Malaria. Donor Government Statistics. 2012; http://www.theglobalfund.org/en/donors/statistics/?lang=en. Accessed June 27, 2012.